Working Together to Reduce Hospitalizations During COVID-19

Jennifer Drake

Continuing Education

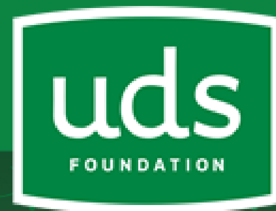
- To complete the course, the learner must:
  - Watch the 30-minute webinar (live or recorded)
  - Complete post-test questions & evaluation
- 0.5 contact hours approved for Nursing
  - Quality Insights is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation
- There are no identified conflicts of interests.

Learning Outcomes

- After this course, the learner will be able to:
  - Discuss the importance and development of specialized in-home programs, including the benefits to both patient and family
  - Explain how hospital tracking can benefit your patients
  - Describe two ideas to implement specialized programs during a pandemic

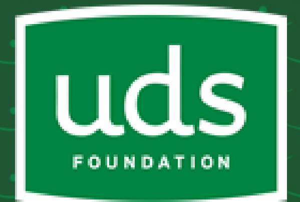
United Disabilities Services/ Independent Living Services Reducing Hospitalizations

Presented by Jennifer Drake



United Disabilities Services Foundation Background and Programs

- 56 years of providing home and community based services to participants in 60 counties in Pennsylvania
- 12 Internal Programs
  - Adult Enrichment
  - Employment Services
  - Transition School
  - Challenger Football and Cheerleading
  - Non-Medical In-Home Personal Care
  - Accessible Home Modifications
  - Mobility and Rehab Equipment
  - Custom Wheelchair Seating
  - Service Dogs
  - Care Management (Supports Coordination)
  - Autism Waiver Care Management
  - Resource Center



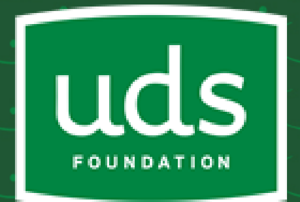
HCBS Reducing Hospitalizations

A Transition of Care (TOC) is when a participant is moving from one setting to another. This puts participants at higher risk for hospital readmissions, medication errors and decreased health.
TOC's require accurate and timely communication between care providers for a successful TOC to take place.

Within 2 days of a hospitalization and discharge we are calling the Participant to ensure health and safety and to make sure we are part of the discharge planning process to ensure a safe discharge home can take place.

Within 5 days of the discharge we are going to the participant's home to follow up with them ensuring they know all the information on our Ticket to Home which outlines the 4 major risk factors people are readmitted to the hospital or NF.
Review Ticket to Home and use a teach back method to ensure they know what to do to stay home and when it is appropriate to call the PCP or the hospital.

With MCO's:
A hospitalization is a "trigger event" which means we will go into the NF or hospital and reassess their needs for a change in services within 48 hours of the trigger event. This visit does not replace the quarterly visits already in place. Being in the facility allows us to connect with hospital or NF staff and be more involved in the discharge process.



In-Home Personal Care Reducing Hospitalizations

Safety Mentor: Monitors safe and unsafe visits daily

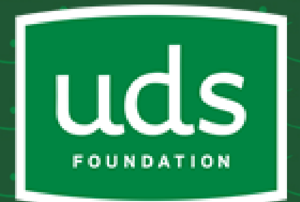
Scheduled home visits to monitor Participant safety

LPN 6 Month Participant Check-in Visits

Hospitalization tracking and ED trends for individual Participants

ILS care team and hospital care management team work closely together for safe discharge and implementation of patient home care plan

Work with Waivers, HealthChoices and private pay consumers



Fall Prevention Programs

UDS Safety Mentor and Home Modifications Professionals:

- Assess participant environment and current transfer status
- Work collaboratively with discharge planners, insurance carriers and participants
- Assess for:
  - Handrails on stairways
  - Adequate lighting
  - Pathways free of clutter, throw rugs
  - Mounted grab bars in tub, shower and commode areas
  - Commode is proper height for function of Participant
  - Movement of Participant up and down stairs for a stairlift if applicable
  - Can work with both home owners and Landlords
  - Waivers, HealthChoices, private pay consumers

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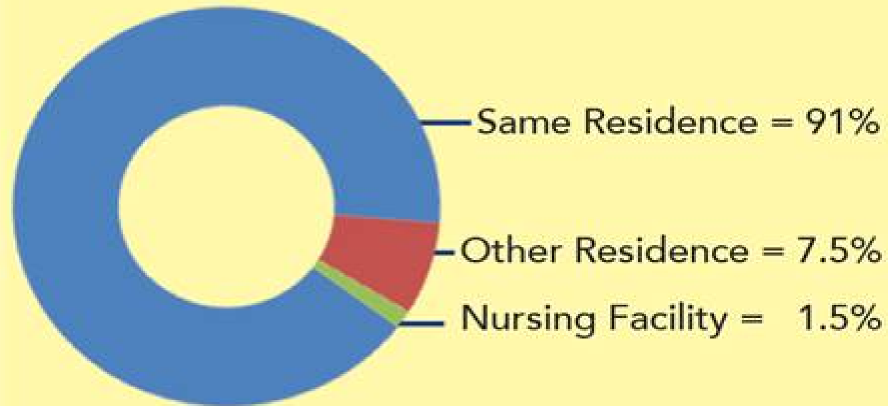
Fall Prevention Outcomes: Home Modifications Study 2018

CRITICAL OUTCOMES

Where Are Participants 1 - 2 Years After Receiving Services?



Has Modification Improved Participant's Health and Safety

Yes = 92%

No = 8%

Falls/Injuries Since Modification

For Myself 21%

For My Caregiver 0%

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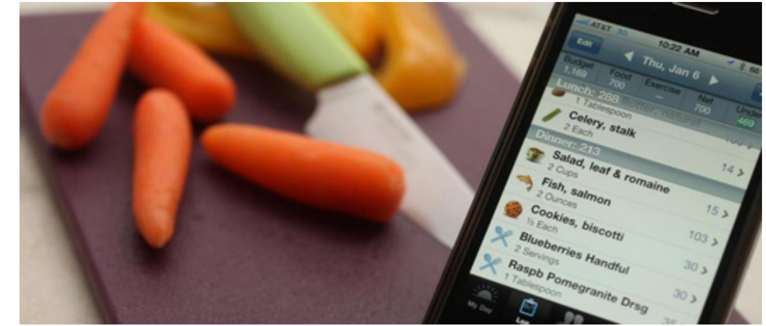
Specialized Programs

Specialized Programs

- Diabetes
  - Patient/family education
  - Nutrition and diet monitoring
  - Working with other care providers
- Wound Care
  - Patient/family education
  - What to look for with their dressings
  - Working with other care providers



Both programs are only successful with participant compliance!

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Increasing Awareness During Covid-19

- Providing In- Home Care During a Pandemic
  - Following all CDC recommendations and guidelines
    - Hand washing/sanitizing
    - Wearing of mask or cloth covering
    - Social distance when applicable
    - Continuously disinfecting environment
    - Report symptoms, quarantine, get tested
  - Electronic and mail In enrollments
  - Zoom family question and answer sessions
  - Caregivers supplied with all proper PPE to provide the very best care to their participants
  - Continuous communication with discharge planners and other care providers in the home
  - Continuous communication and education to participants on CDC safety reminders

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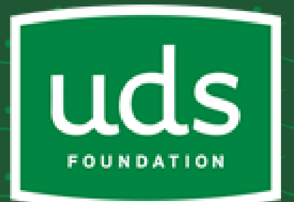
Questions

Please Call UDSF Resource Center at 888-837-4235 for any questions or referrals
Or Jennifer Drake at (570) 900-1421



Polling question

- What is your preferred length of time for an educational webinar/activity that includes nursing contact hours?
  - 30 minutes
  - 45 minutes
  - 60 minutes
  - More than 60 minutes

Thank you!

- To obtain your 0.5 contact hours, please visit https://www.surveymonkey.com/r/JBCDKBK

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